ETEPLIRSEN (EXONDYS 51®) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	
Address:		
Phone:	**Height:** _____ ☐ inches ☐ cm	**Weight:** _____ ☐ lbs ☐ kg **Date weight obtained:** _____

Clinical Information

Primary Diagnosis Description: Duchenne muscular dystrophy (DMD)	**ICD-10 Code:** G71.01

Allergies:

Eteplirsen (EXONDYS 51®) Prescription

Eteplirsen (EXONDYS 51®) refill as directed x 1 year

Infuse 30 mg/kg IV over 35 to 60 minutes every week (+/− 3 days to allow for patient/nurse scheduling).

Dose will be rounded to closest 100 mg.

Flush IV tubing with 0.9% Sodium Chloride 10 to 20 mL after each infusion.

Prescriber will obtain weight for non-ambulatory patients and provide dose changes to pharmacy as needed.

Ancillary Orders

Anaphylaxis Kit

Does this patient require an anaphylaxis kit?

☐ Yes, with 1st dose ☐ Yes, with all doses

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max per dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Lidocaine/prilocaine 2.5%/2.5% (or equivalent) anesthetic cream 30 gm – apply topically 30 min prior to venipuncture or port access as needed for numbing.

☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to: (410) 558-6439

